REGIONAL ONE HEALTH
DISCHARGE SUMMARY

Patient Name: HUGHEY, JAMES A
DOB: 10/1/1971

Account #: 6141230
MR #: 2102258

Race/Sex: CAU/M
Admit Date: 6/8/2017
Dictating Provider: HENKEL, JANE ELYSE

Nursing Unit: 2
Discharge Date: 7/15/2017
Attending Physician: John P. Sharpe, MD

ENC Type: INPATIENT

DICTATING SERVICE: TRAUMA

DISCHARGE DISPOSITION: Home.

DISCHARGE CONDITION: Stable.

DISCHARGE DIAGNOSES:

1. Grade 4 splenic laceration, with pseudoaneurysm.
2. Left rib fractures of 8, 9, and 10.
3. Right ribs 8 and 9 fractures.
4. L1 and L2 transverse processes fractures.

CONSULTING SERVICES:

1. Interventional Radiology.
2. Gastroenterology.
3. Acute pain service.
4. Speech Pathology.
5. Physical Therapy.

OPERATIONS AND PROCEDURES:

1. On June 8th, Interventional Radiology embolization of splenic artery.
2. On June 12th, BAL of the right lower lobe.
3. On June 15th, tracheostomy.
4. On June 17th, toilet bronchoscopy.
5. On June 18th, right chest tube placement.
6. On June 19th, paracentesis.
7. On June 20th, thoracentesis.
8. On June 21st, bronchoscopy with bronchoalveolar lavage of the left lower lobe.
9. On June 27th, EGD.

HOSPITAL COURSE: On June 9, 2017, the patient was admitted to the hospital. He presented as a transfer from an outside hospital with a splenic laceration and rib fractures, status post assault. He was taken to Interventional Radiology for embolization of the splenic artery, and his trauma workup was continued. The patient was found to be increasingly confused, and he required intubation. He was sedated on full vent support for acute respiratory failure with hypoxia. At this time, his white blood cell count was 17.4. His hemoglobin was monitored for post-hemorrhagic blood loss anemia. At this time, his hemoglobin was 8.0, and his hematocrit was 25.1. He was afebrile and was not placed on antibiotics. An ammonia level was checked. DT prophylaxis was initiated due to a history of cirrhosis and chronic alcohol use. Arterial blood gas was obtained, and supportive care was continued. On June 10th, the patient was continued to be intubated and a propofol drip, sedated and will full vent support. The acute pain service was consulted, and he had bilateral rib focus. We continued to monitor his hemoglobin and hematocrit. At this time, his hemoglobin was 6.9, and his hematocrit was 22.2. He continued to be afebrile, with a downtrending white blood cell count at

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11.7. His ammonia was found to be elevated at 100, and the patient was started on lactulose and rifaximin. The nutrition service was consulted for tube feeds, and we continued supportive ICU care. On June 11th, the patient was tolerating his tube feeds. Hemoglobin was 8.5, and hematocrit was 25.6. He continued to have a normal white blood cell count at 10.9, although he did spike a fever to 101.9. We continued to monitor his ammonia level and treat it with lactulose and rifaximin. We continued to treat his alcohol withdrawal, and we weaned vent support as tolerated. On June 12, 2017, the patient continued to be febrile at 102.1, and a bronchoscopy with alveolar lavage was performed. At this time, he continued to require ventilator support, and empiric antibiotics were started per trauma protocol at this institution. He was started on Unasyn for the bronchoscopy, and the cultures were followed. On June 12th, the patient continued sedated and requiring ventilator support. Lasix was given for increased interstitial markings on his chest x-ray, and his anemia continued to be stable, with a hemoglobin of 8.6 and a hematocrit of 27.3. Again, he was febrile at 101, and Unasyn was continued. On June 13th, the patient continued to be febrile, with a temperature of 102.5. His white blood cell count was normal at 10.3, and he continued to require sedation, ventilator support, and treatment for elevated ammonia levels. His blood cultures started to grow alpha-hemolytic strep, and Unasyn was continued. On June 14th, the patient continued to be febrile, with a temperature of 12.5. His white blood cell count was 1.3, and the Unasyn was continued. He was still on ventilator support and was requiring Lasix and lactulose. Spironolactone was added. He was noted to have significant ascites, and Gastroenterology was consulted at this time. He was found to have copious watery diarrhea, and his stool was sent for a C diff toxin study. On June 15th, he continued to be febrile, with a maximum temperature of 102.9. His white blood cell count continued to be normal at 8.8, and his cultures continued to grow alpha-hemolytic strep, plus an unknown organism that was yet to be identified. At this time, Interventional Radiology was consulted for paracentesis, and the patient was consent for tracheostomy. A tracheostomy was performed on June 15th, and the patient continued on ventilator support. On June 16, 2017, the patient continued to be febrile, with a maximum temperature of 102.9. His white blood cell count was still normal at 7.6, and he continued to require ventilator support. Per Gastroenterology's recommendation, his spironolactone dose was increased, and a bedside paracentesis was performed by Interventional Radiology which drained 3 liters of fluid that was later sent off for analysis. On June 17th, the patient continued to be febrile at 101.2, and Unasyn was still continued. A toilet bronch was performed on June 17th for continued infiltrate on x-ray. The patient continued to tolerate tube feeds. His hemoglobin remained stable at 7.5, and his white count remained normal at 7.2. His bronchoalveolar lavage culture grew 20 million CFUs of Streptococcus pneumoniae, 2.5 million CFUs of Streptococcus viridans, and continued to be monitored. Blood cultures x2 obtained on June 11, 2017, continued to be negative at this time as well. On June 18, 2017, the patient's tube feeds were placed on hold after an episode of emesis. His NG tube was placed to suction, which suctioned about 3 liters of fluid. Reglan was started per Nutrition's recommendations. The patient continued to be febrile, with a fever of 103.8. Unasyn was continued at this time, and his white blood cell count continued to be normal at 9.1. At this time, the patient only had intermittent agitation. He was followed commands, and continued on Seroquel and Precedex. He continued on ventilatory support with SIMV, and his chest x-ray on this morning showed a right-sided effusion. Hemodynamically, he was stable, and we continued to treat his elevated ammonia levels. On June 19th, the patient continued to be febrile at 102.7, but finished his Unasyn. A right-sided chest tube was placed for a right-sided effusion seen on CT, and the patient was continued on tube feeds and continued to be treated for his elevated ammonia and respiratory needs. On June 20th, the patient continued to be febrile at 102.7. His white blood cell count was 13.5, and his blood cultures continued to be negative. At this time, he was off antibiotics, was

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hemodynamically stable, and his hemoglobin was stable at 8. His chest x-ray showed to be improving, and he was tried on pressure support trials at this time. He also underwent repeat paracentesis with Interventional Radiology, draining 3.5 liters of fluid, as well as thoracentesis, draining 1.3 liters of fluid. On June 21, 2017, the patient continued to be febrile at 103. His white blood cell count was 13.1, and a bronchoscopy with alveolar lavage was performed. Her continued to require ventilator support, although he was tried on spontaneous pressure support trials throughout the day. Per protocol, the patient was started on cefepime and vancomycin. On June 22, 2017, the patient continued to be febrile with a temperature of 101.9. His white blood cell count was 10.6. At this time, his ascetic fluid was negative, his pleural fluid was negative, and his bronchoscopy sample was growing a few gram-negative rods. Hemodynamically, he was table. His chest x-rays were stable. He continued to have intermittent agitation, but was following commands, and we continued to monitor his hemoglobin, which was stable at 9.3. On June 23, 2017, the patient continued to be febrile with a fever of 102.8. His white blood cell count was normal at 7.5, and his cultures continued to be negative at this time. He was continued on vancomycin and cefepime. His hemoglobin continued to be stable at 9.8, with a hematocrit of 29.6, and he continued to receive supportive care in the ICU. Overnight on June 24, 2017, the patient removed both his NG tube and his Dobbhoff tube. He was continued on total parenteral nutrition, and Speech was consulted to evaluate his swallowing abilities. At this time, he was found to be afebrile, with a temperature of 99.6. He was continued on antibiotics, and his white blood cell count was stable at 8.6. His hemoglobin was 9.5 and hematocrit 28.6. At this time, the patient was on high-flow CPAP. His chest x-ray was stable. He was following commands, and his cultures continued to be followed, but were negative at this time with the exception of his blood cultures on June 22nd showing gram-positive cocci in clusters. On June 25, 2017, the patient's blood cultures showed gram-positive cocci in clusters, and his bronchoalveolar lavage sample grew 110,000 CFUs of Pseudomonas aeruginosa. The Pseudomonas was found to be sensitive to cefepime, and he was continued on antibiotics. At this time, his white blood cell count was 9.8, and his hemoglobin was 10.1. On June 27, 2017, the patient underwent an EGD with Gastroenterology. At this time, his blood cultures were found to be most likely a contaminate, and new blood cultures were obtained. His white blood cell count was 9.5, and his hemoglobin was 9.6. He was put back on the ventilator for acute respiratory distress, although his chest x-ray remained unchanged. He continued to follow commands, and he continued to be afebrile. On June 18th, the patient was placed back spontaneous on the vent. Vancomycin was discontinued, and he was continued on cefepime. His white blood cell count at this time was 10.4, and his hemoglobin was 9.7. On June 29th, the patient was transitioned back to high-flow CPAP. His chest x-ray remained unchanged, and he was continued on total parenteral nutrition. He failed a modified barium swallow per Speech Therapy and was only approved for ice chips at this time. He continued to be afebrile, with a maximum temperature of 99.7, and his white blood cell count continued to be normal at 8.9. His hemoglobin was stable at 9.0. On June 30th, the patient continued on cefepime and treatment for elevated ammonia levels, which were now down to 57. He continued to be afebrile. His white blood cell count was 8.5, and his anemia was stable with a hemoglobin of 9.0. He continued on high-flow CPAP. His chest x-ray remained unchanged, and he was tolerating his tube feeds, and total parenteral nutrition began to be weaned. His EGD showed no active bleeding, and Lovenox was started for DVT prophylaxis. On July 1st, the patient spiked a low-grade fever of 100.7. He was continued on cefepime. At this time, his white blood cell count was 9.8, and his hemoglobin was stable at 10. On July 2nd, the patient continued to have a low-grade fever of 99.9. His white blood cell count was 10.5, and his hemoglobin was stable at 10.6. He continued on cefepime for the Pseudomonas in his bronchoalveolar lavage culture, and he was continued on high-flow CPAP at this time. His ammonia level was found to be trending upward to 113 from 60 just 2 days prior, and his lactulose dosage was

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increased. On July 3, 2017, the patient continued to be weaned to a trach collar, requiring intermittent high-flow CPAP for respiratory distress. He continued to be afebrile, with a T-max of 99.2. He continued on his cefepime, with a white blood cell count of 10.5 and a hemoglobin of 10.6. We continued tube feeds, and his blood cultures were deemed final. On July 4, 2017, we continued weaning to a trach collar. His T-max was 99.6. We continued cefepime for Pseudomonas in the cultures. The patient's white blood cell count was 12.7. His hemoglobin was stable at 10.8. He was found to be agitated, and we started him on Seroquel. The tube feeds were continued. Lasix, rifaximin, Aldactone, and lactulose were continued. His ammonia level continued to be trended. On July 5, 2017, the patient continued to be afebrile, with a T-max of 99.3. Today was his last day of cefepime. His white blood cell count was 12.7, with his hemoglobin stable at 10.8. His agitation improved with Seroquel, and he was successfully weaned to a trach collar, breathing aerosolized FIO2 at 28%. His chest x-ray this morning showed no effusions, infiltrates, or pneumothoraces. His was tolerating her tube feeds, and we continued on treatment for his elevated ammonia, which was 81 today and improving. On July 6, 2017, the patient's maximum temperature was 100.3. He was no longer on cefepime. His white blood cell count was 13.3, with a stable hemoglobin at 10.6. The patient's agitation continued to improve, as well as his respiratory status. He was tolerating the trach collar well, and he was downsized to a size 6 cuffed trach. He was also witnessed walking in the halls of PT and tolerating that well. On July 7, 2017, the patient continued to be afebrile, with a temperature of 98.6. He was not on antibiotics. His white blood cell count was down from 13.3 to 11.6. He continued on Seroquel for agitation. He had failed his modified barium swallow, so we continued tube feeds, and we continued on treatment for his ammonia levels that continued to fluctuate. On July 8th, the patient continued to be afebrile and tolerating the trach collar well. He was switched to a 6 cuffless trach. He continued on Seroquel. His ammonia levels continued to trend downward, and his white blood cell count was 9.6, with a hemoglobin stable at 10.4. On July 9, 2017, the patient continued to be afebrile, without a white count. His hemoglobin was stable. He was now tolerating nasal cannula at 2 liters and started on capping trials with Speech Therapy. His ammonia levels continued to improve, and he continued to work with Physical Therapy. On July 10th, the patient was afebrile and without a white count. His hemoglobin was stable at 9.0, and he was together room air. His trach was capped at this time in preparation for decannulation on July 11th. On July 12th, the patient ambulated well with Physical Therapy. He was up in a chair for most of the day and continued to have a low ammonia level. He was decannulated. He was afebrile, with a white blood cell count of 8.5 and hemoglobin stable at 10.2. We continued to monitor him in the progressive care unit. On July 13th, the patient continued to be afebrile and without a white count. His hemoglobin was stable at 10.9, and his ammonia was stable. On July 14th, the patient remained oriented, without agitation or confusion. He was tolerating room air. His hemoglobin remained stable. He remained without a white count and continued to be afebrile. On July 15, 2017, the patient continued to improve. He was afebrile and without a white count, with a hemoglobin of 10.8. He was discharged home with family.

DISCHARGE INSTRUCTIONS: The patient was discharged on a regular diet and told to follow up if he experienced any worsening confusion, pain, fevers, or any other life-threatening condition. His activity was unrestricted, and he returned home with family.

This document is considered preliminary until authenticated by the attending physician.

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HENKEL, JANE ELYSE

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